Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
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Original Public Report

Report Issue Date: July 2, 2024
Inspection Number: 2024-1454-0003
Inspection Type: Complaint Critical Incident
Licensee: Spencer House Inc.
Long Term Care Home and City: Spencer House, Orillia

Lead Inspector	**Inspector Digital Signature**
Tracy Muchmaker (690)	Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2024.07.04 11:49:14 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 4-7, 2024

The following intake(s) were inspected:

- One intake, which was a complaint related to skin and wound care; and
- One intake, which was a critical incident for an allegation of resident neglect related to skin and wound care.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given the opportunity to participate fully in the development and implementation of the resident's plan of care related to skin and wound care.

Rationale and Summary:
A resident developed a new area of altered skin integrity on an identified date. A progress note identified that the resident's SDM was not notified of the altered skin integrity until two days later.

Registered staff, the Skin and Wound Lead, and the Director of Care (DOC) all stated that the resident's SDM should have been made aware on the day that the wound was discovered.

The delay in notifying the resident's SDM of the area of altered skin integrity and treatment plan presented a low risk to the resident.

Sources: A resident's skin and wound assessments, and progress notes; interviews

with Registered staff, Skin and Wound Lead and the DOC.
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WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that care was provided to a resident as specified in their plan of care related to skin and wound care.

Rationale and Summary:
A resident had areas of altered skin integrity, and had treatment orders in place. The resident's electronic treatment administration record (eTar) indicated that staff were to provide a type of treatment on a specified schedule. There were two occasions during a month that documentation indicated that the treatment was not competed as scheduled.

An RPN, and the DOC confirmed that the documentation indicated that the treatment had not been completed on two occasions in the month, and could not say why.

Not completing the daily treatment for a residents wounds on two occasions in the month presented a low risk to the resident.

Sources: A resident's eTar, and progress notes; interviews with Registered staff and

the DOC.
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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident's areas of altered skin integrity was re-assessed at least weekly.

Rationale and Summary:
A resident had an area of altered skin integrity that was noted to be worsening during an assessment. The assessment took place more than seven days after the previous assessment.

Registered staff and the DOC both confirmed that an assessment should have been completed every seven days.

Not completing the skin and wound assessment within seven days presented a risk to the resident.

Sources: A resident's skin and wound assessments and progress notes; interviews

with Registered staff, Skin and Wound Lead, and the DOC.
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WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The licensee has failed to ensure that when a resident exhibited a skin condition that was likely to require or respond to nutrition intervention, such as pressure injuries, and foot ulcers, was assessed by a registered dietitian (RD).

Rationale and Summary:
A resident presented with a new area of altered skin integrity on an identified date. Progress notes indicated that a referral was not sent to the Registered Dietitian (RD) until a number of days later.

Registered staff, the Skin and Wound Lead, and the DOC confirmed that a referral to the RD should have been sent on the day the altered skin integrity was identified.

The delay in sending the referral to the RD presented a risk to the resident.

Sources: A resident's skin and wound assessments, referrals, and progress notes; the home's skin and wound care policy; interviews with Registered staff, the Skin and Wound Lead, and the DOC.
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